CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION . DUE DISC. 01			(X3) DATE SURVEY COMPLETED	
155777		A. BUILDING		08/13/2012			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					CREASY LN		
CREASY SPRINGS HEALTH CAMPUS				'ETTE, IN 47905			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG				PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	REGUENTORTOR	ESC IDENTIFITING INFORMATION)		1710	<u> </u>		DATE
K0000	State Licensure Assurance Walk conducted by t Department of accordance wit Survey Date: 0 Facility Number Provider Numb AIM Number: 2 Surveyor: Bridg Safety Code Spr At this Life Safe Creasy Springs was found not Requirements f Medicare/Medi Subpart 483.70 from Fire and t the National Fire Association (NF Code (LSC), Che Health Care Oc IAC 16.2. The facility was	k-thru Survey were he Indiana State Health in h 42 CFR 483.70(a). 8/13/12 r: 012285 er: 155777 201006770 get Brown, Life ecialist ety Code survey, Health Campus in compliance with for Participation in caid, 42 CFR D(a), Life Safety he 2000 edition of re Protection FPA) 101, Life Safety apter 18, New cupancies and 410	K00	000	The submission of this POC donot indicate an admission by Creasy Springs Health Camputhat the findings and allegation contained herein are accurate and true representations of the quality of care and services provided to the residents of Creasy Springs Health CampuThe facility maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. This POC will serve the credible allegation of compliance with all federal and state requirements governing management of this facility.	us ns e us. e or as	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

012285

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF CORRECTION OF CORRECTION 155777	(X2) MULTIPLE CC A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 08/13/2012			
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				
	Type V (111) construction. One certified health care occupancy was located on the north end of the main building with a capacity for 44 and a census of 42 residents. Certified Health care rooms L201 to L208 in the Legacy building have the capacity for 10 residents with a census of 10. The entire building was surveyed since there was no separation from the assisted living occupancy. The facility has a fire alarm system with hard wired smoke detection in corridors, spaces open to the corridor and in resident rooms. The facility has the capacity for 65 and had a census of 61 at the time of this survey. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas where the residents have customary access and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/21/12.						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMI	e survey pleted 3/2012
NAME OF P	PROVIDER OR SUPPLIEF	<u> </u>		ADDRESS, CITY, STATE, ZIP C	CODE	
CREASY	SPRINGS HEALTI	H CAMPUS		CREASY LN ETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE J DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	The facility was compliance wit aforementione	s found not in th the				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
		155777	B. WING		08/13/2012	
NAME OF B	AD CHARLED OR CHARLIED		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		1750 S	CREASY LN		
CREASY SPRINGS HEALTH CAMPUS			LAFAY	ETTE, IN 47905		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
K0018 SS=E	NFPA 101 LIFE SAFETY CO	ODE STANDARD				
33-L		corridor openings are				
		sist the passage of smoke.				
		ed with positive latching				
		doors meeting 18.3.6.3.6				
	are permitted. Ro	oller latches are prohibited.				
	Based on obse	rvation and	K0018	The facility immediately	09/12/2012	
	interview, the f	acility failed to		contacted our door and hardw		
	ensure 2 of 2 c	louble door sets		vendor to request replacement manual double door latches w		
	protecting corr	idor openings were		constant latching door bolts.		
	equipped with			An inspection of all double do		
		e door frame. This		was conducted and all manua		
		ce affects staff,		latching mechanisms identified	d.	
	-	or more residents		Contractor provided an estimate for replacement of		
				manual door latches with		
		ampus and Legacy		constant latching bolts. Facility	ty	
	buildings.			has given approval to contract	tor	
	Findings includ	le:		to proceed with ordering the replacement latches and has requested scheduling of this		
	Based on obse	rvation with the		work.4. Routine maintenance	od	
	maintenance d			rounds are logged and review monthly in QA&A meetings.	eu	
		veen 12:05 p.m.				
	· · · ·	corridor double				
	door sets acces					
		the Health Campus				
	_	•				
		rage room in the				
		g each required one				
		nually latched into				
		before the second				
	door would late	ch into the first				
	door and secur	e them both tightly				
	into the door fi	rame. The				
	maintenance d	irector				

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	OF CORRECTION	IDENTIFICATION NUMBER: 155777	(X2) MULTIPLE CO A. BUILDING B. WING	01	08/13	LETED 6/2012	
NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
	regulatory of acknowledged observations,			CROSS-REFERENCED TO THE DEFICIENCY	HE APPROPRIATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			COMPLETED		
155777			B. WING			08/13/2012	
			p. ,,		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CREASY LN		
CREASY SPRINGS HEALTH CAMPUS			LAFAYETTE, IN 47905				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	E C	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG K0048 SS=F	NFPA 101 LIFE SAFETY CO There is a written all patients and for event of an emerg Based on recorr interview, the frinclude the type extinguishers as use in the writt protection of 7 the event of an 19.7.2.2 requir care occupancy that shall provi following: (1) Use of alarm (2) Transmissic fire departmen (3) Response to (4) Isolation of (5) Evacuation of (6) Evacuation of (6) Evacuation of (7) Preparation building for eva (8) Extinguishn The plan shoul of fire extingui any special requisage.	DDE STANDARD plan for the protection of or their evacuation in the gency. 18.7.1.1 d review and facility failed to es of fire available and their ten fire plan for the 6 of 76 residents in emergency. LSC res a written health of fire safety plan ide for the 10 alarms fire of immediate area of smoke 10 of floors and accuation 10 of floors and 10 of floors	K00	TAG	1. The Fire action plan was updated including identification and use of the K-class Fire Extinguisher's as well as the Ansul extinguisher system which are located in th kitchens.2. No other fire extinguishers meet these classifications.3. All copies of campus fire action plan have been replaced with the update plan.4. Quality Assurance Committee will review the updated fire plan.	e	DATE 09/12/2012

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	of Correction identification number: 155777	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPI 08/13	LETED	
	PROVIDER OR SUPPLIER SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
TAG	Findings include: Based on review of the Fire Plan with the maintenance director on 08/13/12 at 2:20 p.m., the plan did not identify available fire extinguishers and their use. The maintenance director acknowledged at the time of record review, these elements were not addressed in the fire plan. 3.1–19(b)	TAG	DEFICIENCY)		DATE	

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